THE SOCIAL AND REHABILITATION

Record

Utilization Control . R&D . Serving Deaf People . Computers . Preventive Medicine . Careers . EPSDT . Rehabilitation Plans

Social and Rehabilitation Service UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE Volume 2/Number 1/December-January 1974-75

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Seeing is believing.

He will never find the answer if he can't see the problem.

If your child needs glasses, the Medicaid Program can provide them. Just as we provide immunizations against polio, whooping cough, and measles . . . treat anemia, TB, and sickle cell disease. To find out if your family is eligible, contact your local Social Service or Welfare Office today.

Medicaid. Worth looking into.

THE SOCIAL AND REHABILITATION
Record

Volume 2, Number 1 December-January 1974-75

ARTICLES

5 A Child's Good Health — Thomas Brubeck
Describes the early and periodic screening, diagnosis, and treatment program, a large scale venture in preventive medicine for high-risk populations.

10 Interpreter Consortium: A Sign for the Future — Frank Romano
More interpreters—better trained interpreters and better geographically distributed interpreters—are needed.

11 A New Approach to Serving Deaf People — Frank Bowe and Douglas Watson, Ph.D.
A model for services to the deaf is proposed that would use the best of the two delivery systems now in operation.

16 How the Computer Works
What can a computer do that a man with a library, a phone, and a pad of paper can't do? Nothing. But the computer does it infinitely faster!

18 Interdisciplinary Management of Developmental Disabilities Cases — William Howard
Recognizing developmental disabilities and misrecognizing them can be a problem for professionals who do not work directly with these people.

24 Individualizing Rehab Plans for Cost-Effective Gains — Anthony S. DeSimone
"There is a need to develop an institutionwide operational philosophy based on habilitation rather than custodial care."

29 Utilization Control in Medicaid — Izanne Leonard
Explains the Social Security Amendments of 1972 that established broadscale controls over the use of health services paid for by Medicaid.

DEPARTMENTS

4 Regional Report

15 Research and Demonstrations

22 Publications and Films

28 The Administrative File

32 Career Opportunities

34 Etcetera

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Counselors sample life in wheelchair

Wheelchairs replaced conventional chairs at a recent training session on spinal cord injuries at Cosa Colinas hospital in Pomoma, Calif.

The 60 rehabilitation counselors and other staff members were "assigned" disabilities during the 2-day program in order to experience the problems of someone who has received a spinal cord injury.

Some trainees found themselves using devices to hold silverware and picking up a glass at mealtime. Other experiences included driving a hand-controlled car and operating a driver-simulator with hand controls; transferring from a wheelchair to a car, using a sliding board; transporting a wheelchair in a car; and household organization and use of various devices such as splints for simple daily activities.

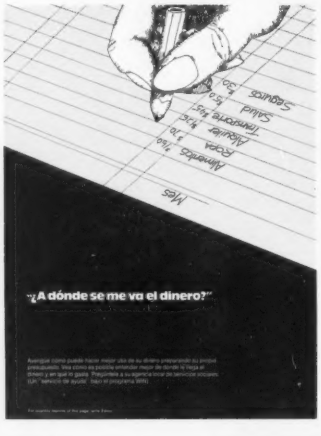
Being wheelchair-bound during the 2 days resulted in their becoming more aware of mobility barriers as well as the amount of time and energy it takes for locomotion.

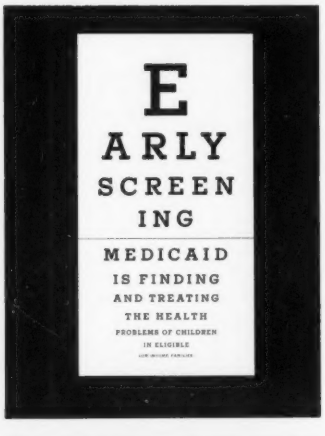
Reactions reportedly were enthusiastic. The trainees said the difficulties they experienced as a result of the simulated disabilities increased the impact of the course and made the lectures more meaningful.

MR guidelines sent to defense depots

Guidelines used at a defense depot in Tracy, Calif, to help in working with mentally retarded employees were considered to have widespread use and were distributed by the Defense Supply Agency headquarters in Alexandria, Va., to its 23 units throughout the country. The guidelines used in Tracy were developed by Bruce MacKinnon.

FREE WAYS TO WIN PEOPLE AND INFLUENCE FRIENDS





Posters to reach employees or the general public are available to your agency through THE SOCIAL AND REHABILITATION RECORD. They appear as editorial displays in the magazine each month. Free reprints such as the ones shown here can be ordered by State and local agencies in quantities of up to 50 copies each.

A Child's Good Health

THOMAS BRUBECK

In a program that makes medical services available to people of low incomes, it was inevitable that attention eventually would focus on their children and the generations to come.

When Medicaid added a program of early periodic screening, diagnosis, and treatment (EPSDT) in 1968, it was its first large scale venture into preventive medicine and, particularly, for a so called "high-risk" population group.

The concept is beautifully simple, something both doctor and patient can appreciate.

Why EPSDT?*

It costs less in lives and money. . .

- **to prevent than to treat**
- **to treat than to rehabilitate, and**
- **to rehabilitate than to provide life-long care.**

*Early periodic screening, diagnosis & treatment

Thus, it begins with prevention: To prevent illness and disease in order to avoid a more expensive and perhaps unsuccessful treatment; to treat an illness or disease early rather than go through a process of rehabilitation at some later and more difficult stage; and to rehabilitate, when necessary, to prevent a lifetime of institutional living.

Q. But what's new? Isn't such preventive practice an accepted thing?

A. Yes and no. Generally "yes" for the more affluent and "no" for the poor. The result is that the entire country is poorer for the lack of a systematic way of helping children while there is time to correct an illness or other health problem.

Elsie Tytla, M.D., a child health consultant on EPSDT with the Medical Services Administration, points out that in addition to placing emphasis on seeking out children of low-income families, EPSDT goes beyond earlier screening programs and tries to assure diagnosis, treatment, and follow up of deficiencies uncovered.

"Historically, most screening programs had built-in failure, because everything stopped there," she said. "Responsibility ended with referral of the patient. The ideal program would fit EPSDT within the scope of regular pediatric care in a one-to-one relationship with a physician." Often this is not possible because of scarce resources and alternatives have to be found. Preventive health is important to children because of their unusual vulnerability and the long duration of any handicaps acquired early in life.

Children are especially vulnerable if they happen to live in a low-income home. Dr. Tytla said that the number of untreated conditions, morbidity rates, the number of restricted-activity days, and amount of chronic disability are greater for low-income people than for those in higher income population groups.

Studies have shown that children born of poor parents have twice the risk of dying before their first birthday. Fifty percent of poor American children still have not been immunized against polio, and 9 percent are mentally retarded by the age of 13 due to lead poisoning. It is estimated that poor children have 3 times more heart diseases, 7 times more visual impairment, 6 times more hearing defects, and 5 times more mental illnesses than children of more affluent families.

One of the most significant facts on preventive health concerns dentistry. Almost all children have some dental problem by the time they are 6 years old, yet 40 percent of poor children have not seen a dentist by the time they are 17 years old.

"In short," said Dr. Tytla, "illness and disease have been shown to be

more prevalent among the 25 million children who are poor or near-poor than among the 55 million children from more affluent families and much of this disability is preventable."

Of the 25 million children, about 13 million are eligible for Medicaid—that is, they can be reached through the EPSDT program.

EPSDT attempts to introduce eligible children into the health care system and to reach them before health problems become chronic and expensive to treat.

Q. Fine. Helping tomorrow's citizens is noble work, but what does it do for me, the overburdened taxpayer?

A. It will save money. Preventive medicine increases the chances that welfare children will become productive members of society. That is, they will be independent and self-supporting.

Dr. Tytla said it is known that poverty and health status are interrelated, that untreated health defects lead to disease and disability, and that disability leads to dependency and in turn to the perpetuation of the welfare cycle. EPSDT tries to provide health services which at least will correct the *health*-related causes of disability, dependency, and poverty.

The alternative to early health care often is to let damage become irreversible, which is a rough situation for someone just starting out in life. Irreversible means one doesn't get another chance. It has the finality of a steel door clanging shut in prison. It's like being born retarded because of a lack of prenatal care. Or it's like a young child living with heart disease because of untreated streptococcus infection and rheumatic fever.

Q. What are examples of savings in early health care?

A. Perhaps the greatest potential in preventive medicine is in the area of infectious diseases, especially in immunization against disease. In 1900, infectious disease accounted for 37 percent of all deaths in the U. S. By 1969, this was down to about 5 percent. Much of the reason for this decline lies in the use of vaccines against diphtheria, whooping cough, tetanus, polio, measles, and rubella.

Those whose medical interest is confined to fiscal matters will be interested in the immunization effort against measles. The savings are broader than the usual scope of "cost-benefits."

First, of course, is the radical drop in the incidence of the disease. Four million cases a year in 1963 decreased to one-quarter million cases in 1968. During that 5-year period, according to the National Communicable Disease Center, the immunization effort averted about 10 million acute cases of measles and 3,200 cases of mental retardation. It also is estimated to have saved 973 lives, 555,000 hospital days, 291,000 years of normal life, 1.6 million workdays, 32 million schooldays, and $423 million.

A child who contracts rheumatic fever—in the eyes of an actuary—now has a price tag of about $22,000. The annual expenditure for rheumatic fever treatment is about $428 million. Yet, routine throat cultures of school absentees between the ages of 6 to 15 years with respiratory illness or unexplained fevers could be expected to prevent 75 percent of rheumatic fever episodes, and the program could be financed at $7.15 a year for each child. In communities which have at least one case of rheumatic fever per thousand population, benefits from this surveillance program would be about 14-fold.

Immunizing 4 million children against rubella could cost about $3.5 million a year, which is 40 times less than the $140 million that was spent in caring for child victims of the 1964 rubella epidemic.

The experience of rehabilitation work during the past half century has shown that benefits do not return to the health sector alone. There is less need for long term institutional care and public assistance, and there will be future earnings. Rehabilitated persons begin paying taxes and drawing less welfare, and it is estimated that as a result the taxpayers recoup their rehabilitation costs in 3-1/2 to 5 years. One study cited 30 to 1 cost-benefit ratios for money spent for the rehabilitation of mentally retarded persons, 23 to 1 for the physically handicapped, and 22 to 1 for the emotionally ill.

Q. What is the Federal government's role in EPSDT?

A. The program is part of the federal health concern for the protection of children during those crucial years of early development. The federal role is to assure the provision of services and effective use of resources.

The Federal Government provides leadership and technical assistance. The "stick" is about as minimal as that used by any other agency. M. Keith Weikel, Ph.D., Commissioner of MSA, said that, as of July, the government can reduce by 1 percent the federal funds allocated to a State

for the Assistance to Families with Dependent Children program (AFDC) in cases where the State does not carry out the EPSDT program.

As usual, the Federal Government allows the States almost limitless flexibility in arranging for health services. To avoid chaos and irresponsibility, however, the government encourages the States to monitor and evaluate their EPSDT programs.

Q. Doctors are busy people. Where can you find enough physicians and dentists to screen millions of children?

A. To make too much out of a tight manpower problem would be to trivialize medicine and its practitioners. Dr. Tytla, who is a pediatrician, spoke about the doctors' moral obligation to extend themselves a bit to help in an area of preventive medicine where there is big economic and social profit.

"In certain organized settings nurses and paraprofessionals can be utilized for the screening phase while physicians are reserved for diagnosis and treatment services," said Dr. Tytla. "Medical assistants have been used successfully in many areas. Such arrangements greatly expand the available resources. Whatever arrangements are made, the plan for providing services to Medicaid children should be worked out at the local level both by the State Medicaid agency, which has the responsibility by law, and the State medical professional organizations which have a moral responsibility."

The government is urging States and communities to set up professional committees to work with the Medicaid agencies and consumer representatives. Dr. Weikel said this group can help delineate the scope of the EPSDT program; develop a network of resources, including paraprofessionals; provide technical and professional assistance; help in arranging for renumeration for the providers; work out procedures for

reporting data; and work with legislative bodies in improving the program.

There has been considerable success in Mississippi, which was one of the last States to establish a Medicaid program but one of the first to institute EPSDT. The program began there even before the federal regulations were in effect. In a 4-month period, 1,200 children were screened and this uncovered 1,300 abnormalities. Twenty-five percent of the children had multiple dental caries, 20 percent were anemic, 20 percent had enlarged tonsils and pharyngitis, 10 percent had vision problems, 5 percent had hearing problems, and 5 percent had heart conditions. Other problems included intestinal parasites, impetigo and other skin conditions, hernias, asthma, mental retardation, behavioral disorders, kidney trouble, speech defects, and hypertension. Seven cases of child abuse also were uncovered.

Many professionals say that the EPSDT preventive care program should be regarded as more of an opportunity than as a directive.

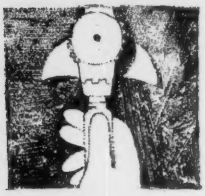
Q. How do low-income people feel about EPSDT?

A. Poor people are not accustomed to using preventive health measures. They seldom go to doctors when they think they are well, even when the services are available and the need to pay for them is not a problem. Their definition of illness often seems different. That prevention is the first and most effective health measure is a new concept for many persons, but especially for people with low incomes, and it underscores the education problems of any new program involving large numbers of people.

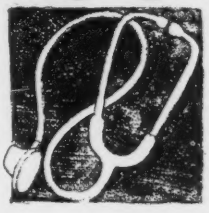
Physicians say that vision defects are among the most common handicapping conditions of childhood. An entire population can have cloudy vision. EPSDT is showing us how to see more clearly that the way to a child's good health is to let him start healthy and keep what he already possesses.

Mr. Brubeck is a contributing editor to *The Social and Rehabilitation Record.*

Children should be seen.

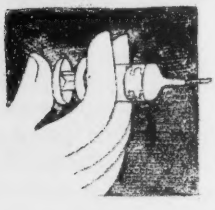


And heard.

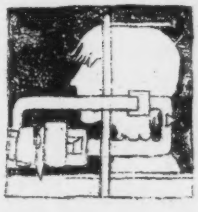


And ahhh'd.

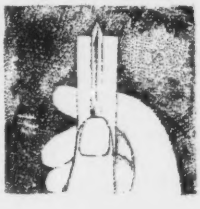
And needled.



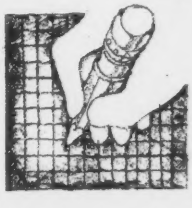
And measured.



And tested.



And charted.



And treated.

Preventive health services are important to vulnerable children . . . especially those from poor families, who have 3 times as much heart disease, 7 times the visual impairment, 6 times the hearing defects, and 5 times the mental illnesses. That's why there is an EPSDT program . . . Early and Periodic Screening, Diagnosis, & Treatment. Children in Medicaid families qualify for EPSDT.

For more information, see your local health or welfare office or write Commissioner, Medical Services Administration, Washington, D.C. 20201.

Interpreter Consortium: A Sign for the Future

FRANK ROMANO

John is deaf. He enjoys an active social life, and through sign language he is able to communicate with his wife and son, who have normal hearing.

But when he consults with his physician, lawyer, rehabilitation counselor, or other professional, or when detailed technical information is involved, he is at a loss.

He could ask a family member or friend who knows sign language to interpret for him. But unless his interpreter is highly skilled and able to explain difficult concepts in sign language too many important details will be missed. At such times, a deaf person needs a specially trained interpreter—one who can translate into sign language the technical terms and concepts so that the deaf person can intelligently make the important decisions that affect his life.

The interpreter, in addition to being highly skilled, must operate under a definite code of ethics. He must keep confidential the personal information revealed through him.

To help John and others with similar problems, a program was established in 1972 to set standards for interpreters and to certify them as professionals according to their skill levels. The Registry of Interpreters for the Deaf, Inc. (RID), with chapters in 43 States, awards certificates based upon an examination which classifies them according to four skill levels.

Skilled interpreters are in critical short supply. Nationwide, there are 305 certified interpreters and 450,000 deaf people. This works out to 1,475 deaf persons per interpreter. Twelve States have no certified interpreters, even though their combined deaf populations total 22,776.

In a major effort to make more qualified interpreters available, the National Interpreter Training Consortium (NITC) was established in February 1974 and is funded under a $107,845 SRS rehabilitation training grant, running from June 1974 through March 1975. The consortium consists of six member institutions: California State University, Northridge; Gallaudet College, Washington, D.C.; New York University, New York; St. Paul Technical-Vocational Institute; University of Arizona, Tucson; and University of Tennessee, Knoxville.

In cooperation with RID, NITC seeks to:

Increase the number of qualified interpreters;

Assist State vocational rehabilitation agencies in improving their use of available interpreter resources in the delivery of case services to deaf clients and in developing new resources;

Develop in each State at least one facility for training interpreters.

To achieve its first goal, NITC will hold workshops for 300 interpreters who have not yet been certified by RID, but are now serving as interpreters. Then, as efforts at upgrading continue, a program will begin to recruit and train people who have had no previous experience as interpreters. A special short term training program will provide interpreters for low-verbal deaf persons—the many who have had little or no formal education or the few who come from non-English speaking families. This kind of interpreting demands extraordinary skill in exchanging thinking by use of hand and body "gestures" that are not related or similar to formal language.

In its goal to assist State vocational rehabilitation agencies, NITC will contact Regional and State offices to determine the interpreting needs and resources in every area and to develop a training plan for each State.

NITC and the State vocational rehabilitation agency will jointly select at least one person in each State to become a teacher of interpreters in the next 5 years. In States where more than one trainer of interpreters is needed, support will be sought from the State or Region to provide training for additional personnel.

Dr. Jerome D. Schein, NITC project director and director of the Deafness Research and Training Center at New York University, said that although the project was initiated last summer, a number of workshops have already begun since August to assist interpreters from more than eight States in achieving certification.

It may not be long now before John has his interpreter.

Mr. Romano is a writer in the Division of Editorial Services, Office of Public Affairs, SRS.

A New Approach to Serving Deaf People

FRANK BOWE and DOUGLAS WATSON, PH.D.

Deafness presents unique challenges to rehabilitation. The handicap may interfere with acquiring information about available services, as well as with understanding and being understood in counseling situations. It also interferes with evaluation, training, placement, and followup. Service delivery is further complicated by the relatively low prevalence and uneven distribution of deafness in the general population. About 400,000 Americans become deaf before reaching the age of 19, the bulk of whom reside in urban areas where jobs, services, and fellowship with other deaf people are readily available.

Rehabilitation traditionally has attempted to serve deaf people in one of two ways, neither of which has been entirely satisfactory. In practice general counselors, who have no special preparation in work with deaf clients, and rehabilitation counselor-with-the-deaf specialists (RCD's) have provided services to this clientele. Communication difficulties and counselor's unfamiliarity with the handicap often have restricted the quality and scope of services general counselors could provide. Alternatively, the feasibility of relying exclusively upon specialists and special facilities was questionable: Is it in fact necessary to remove deaf clients from general counselor caseloads and to segregate services?

Research and practice in deafness rehabilitation indicate that although there are distinct advantages and disadvantages to both approaches, no major efforts had been made to explore means of integrating or maximizing the effectiveness of these two

service delivery systems. In the spring of 1972, SRS asked New York University Deafness Research & Training Center to design, implement, and evaluate a model for improving service delivery with deaf clients. The center was requested to focus particularly upon serving ethnic minority deaf persons living in the inner city.

Developing a Model

The project's first task was to determine the size and problems of the target population. A sample of 412 deaf persons living in New York City was drawn, and 250 people were successfully interviewed. Findings were combined with those of the National Census of the Deaf Population's New York City sample to produce estimates of population characteristics, distribution, problems, and service needs with sufficient precision to guide development of the model.

Particularly striking were findings of undereducation (9.4 median school years completed), underemployment (low-level jobs with corresponding low incomes), multiple health needs (one-third reported having one or more health problems in addition to deafness), and lack of information about service availability (7 in 10 knew of no service agency available to help them with their problems). The findings generally were more pronounced for nonwhites than for whites.

The study suggested that deaf persons requiring rehabilitative assistance most often contact service programs near their homes but are frustrated due to communication and related limitations that arise from the unique problems confronting them. The project gave birth to the concept that their rehabilitation might require expanding the traditional scope of rehabilitation services to include outreach and cooperation among different social service agencies. A coordinating team of deafness rehabilitation specialists performing outreach, consultative, and communication support functions seemed to be a feasible means of accomplishing this expansion. First, however, the service capabilities of existing community agencies needed to be assessed.

A sample of 212 agencies was drawn at random from a directory containing information about 1,200 New York City social service agencies. Questionnaires about services to deaf clients were mailed to them. Where necessary, mail and phone followups were conducted. One hundred and forty-eight agencies (69.8 percent) responded. Two in three were willing to accept deaf clients. Almost half had in fact served one or more deaf clients in the preceding year. Most important, virtually all were willing to serve deaf persons, provided their unique communication and service needs could be accommodated.

Together with the results of the deaf population study, these findings suggest that deaf people need, and with the necessary support can receive, a diversified range of specialized services. A model for providing supportive services to the deaf community, in the form of outreach and referral, and to the agencies, in the form of consultation on service delivery and communication support, was then designed.

The model specifies that a small coordinating team of deafness rehabilitation specialists functions as a bridge between the deaf community and the social service system. Composed of one or more RCD's, a part- or full-time deaf paraprofessional and a secretary-interpreter, the team performs outreach functions to bring deaf persons in need of services into the service delivery process. Short term counseling to identify presenting needs and to initiate referral procedures to appropriate community specialists in the need area are provided for the deaf person.

Service workers at the referral agency are informed of the need and of the client's deafness. If requested, consultation on the case is provided. The team provides interpreters for initial interviews at agencies which do not yet have provisions for interpreting fees. Additional consultation and follow-along support are provided, as needed, until the case is terminated. Upon request, team members provide short term, intensive orientation to deafness seminars for service workers. Agency administrators receive information about characteristics of the deaf population and suggestions for improving services to them.

This basic process may not be followed if the client is severely disabled and appears unlikely to benefit from any but specialized services. Team members generally provide counseling and refer the client to specialized facilities for evaluation and training, as needed.

The model, then, uses both general counselors and specialists, general community service agencies and special facilities. It can handle virtually any need, from hearing aids to job placement. The model's flexibility allows implementation in vocational

rehabilitation agencies and other service programs in cities and States having widely varying deaf populations. It fits in readily with the recently proposed Model State Plan for Vocational Rehabilitation of Deaf Clients. While the Model State Plan presents minimum standards for statewide systems, the current model presents guidelines for actual service delivery. These features, however, are meaningless if the model is not an effective and efficient one. Evaluation in different settings and with different populations is essential.

Implementation and Evaluation

To test the model's general applicability to different settings, an evaluation was undertaken concurrent with implementation in a private university, a major metropolitan comprehensive health center, a private rehabilitation facility, and a State rehabilitation agency.

At New York University, a model team of two RCD's, one deaf paraprofessional, one secretary/interpreter, and seven part-time counselor interns implemented the model for a 24-month period. Its relatively large size reflects New York City's large deaf population. The model team utilized a wide variety of community service resources to meet the wide-ranging needs of more than 400 deaf clients. The population served was characterized by low income (50 percent reported incomes below $3,000), lack of training (half were unskilled or semiskilled); and ethnic minority group status (43 percent were black, Hispanic or Oriental).

The case finding techniques used were successful in bringing the target population, which consisted of deaf innercity residents, into the service delivery system. Short term counseling and referral services proved particularly successful with better prepared clients, while clients more severely handicapped often required diagnostic evaluation prior to referral.

Meeting the needs of a deaf population seems, on the basis of experience with these clients, to require close cooperation between specialists in deafness rehabilitation and general service workers.

At the Dr. Martin Luther King, Jr. Comprehensive Health Center, which is affiliated with Montefiore Hospital in the Bronx, family health workers received orientations to deafness and intensive sign language training prior to establishing the model. The center is developing a registry of all deaf persons in its service area and is utilizing this information in service delivery much as did the NYU model team with data from its deaf population study. Implementation and concurrent evaluation in selected locations outside of New York are currently being developed to further evaluate and refine the model.

While final analyses remain to be undertaken, a preliminary assessment may be made. To be considered effective, a model for service delivery must provide a wide range of services to encompass the target population's needs, an acceptable level of quality in the services rendered, continuity of service delivery over time, economy, and adaptability for meeting the needs of similar populations in different locations. Data on hand and emerging trends suggest that the model may meet these criteria.

The model appears successful in bridging the gap between deaf consumers and community services. Deaf persons with needs are found and brought into the service delivery process. Consultation and technical support by specialists enable professionals in a multiplicity of service areas to serve deaf people. Deaf people, instead of having to rely upon uncertain communication, on the one hand, or a limited range of services, on the other, may soon receive a broad range of high quality services in their own communities.

Mr. Bowe is Coordinator of Service Research and Dr. Watson is Director of Service Research, Deafness Research & Training Center, New York University, 80 Washington Square East, New York, N.Y. 10003.

Research and Demonstrations

In some instances recent project reports can be obtained from the grantee (addresses given below). When the report is not available from the grantee, it may be purchased from the National Technical Information Service, Springfield, Virginia 22151. Remittances should accompany orders; prices are $3 for hard cover and $.95 for microfiche copies.

ARKANSAS STUDIES IN VOCATIONAL REHABILITATION—SERIES I—MONOGRAPH III: REHABILITATION COUNSELOR INTERVIEW BEHAVIOR AND CLIENT OUTCOME IN A COMPREHENSIVE REHABILITATION FACILITY. (12-P-55219) Arkansas Rehabilitation Research and Training Center, Univ. of Arkansas, Arkansas Rehabilitation Service. 53 pages.

REASEARCH FEASIBILITY STUDY. (12-P-55948) National Chicano Social Planning Council, Inc., 425 West Hedding St., San Jose, Calif. 95110.

DEVELOPMENT OF MODERN VOCATIONAL OBJECTIVES FOR SEVERELY DISABLED HOMEBOUND PERSONS: REMOTE COMPUTER PROGRAMMING, MICROFILM EQUIPMENT OPERATIONS, AND DATA ENTRY PROCESSES. (12-P-55077) George Washington Univ., Rehabilitation Research and Training Center, #9, 2300 Eye St., N.W., Washington, D.C. 20037. 323 pages. 75 pages.

The following reports on research in education may be ordered from ERIC Documentation Reproduction Service, Post Office Drawer O, Bethesda, Md. 20014. Microfiche (MF) copies are $.65 each. Hard copies (HC) are $3.29 each for reports of 1 to 100 pages; $6.58 each for reports of 101 to 200 pages; $9.87 for reports of 201 to 300 pages; and $3.29 for each additional 100 pages or portion thereof. Order by accession number (in parentheses) and make checks payable to EDRS. Official institution, State and Federal Government, and company purchase orders are accepted.

ADAPTATION MODE AND BEHAVIOR OF URBAN ANGLO AMERICAN AND RURAL MEXICAN CHILDREN. (ED076248) California Univ., Los Angeles. Early Childhood Research Center. 89 pages.

BENEFIT-COST ANALYSIS AND THE EVALUATION OF MENTAL RETARDATION PROGRAMS. (ED075960) Urban Inst., Wash., D.C. 34 pages.

MEXICAN AMERICAN: AN ANNOTATED BIBLIOGRAPHY OF DOCTORAL DISSERTATIONS. ERIC-IRCD DOCTORAL RESEARCH SERIES, NUMBER 1, MAY 1973. (EDO76714)

UTILIZATION OF TEACHER AIDES IN PUBLIC SCHOOL PROGRAMS FOR EMOTIONALLY HANDICAPPED CHILDREN (ED084734) New York State Education Dept., Albany. Div for Handicapped Children; New York State Education Dept., Albany. Div. of Teacher Education and Certification. 55 pages.

KANSAS CITIZENS PLAN COMPREHENSIVE MENTAL RETARDATION SERVICES. SUMMARY AND RECOMMENDATIONS. (ED084735) Kansas State Dept. of Social Welfare, Topeka. Div. of Institutional Management. 83 pages.

RESEARCH RELATING TO THE LEARNING OF CHILDREN IDENTIFIED AS HAVING EXPERIENCED MALNUTRITION AND/OR HEAVY METAL POISONING. FINAL REPORT. (ED084736) Wisconsin Univ., Madison. Dept. of Psychology. 42 pages.

METHODS AND MATERIALS IN THE EDUCATION OF THE VISUALLY HANDICAPPED. (ED084737) Association for Education of the Visually Handicapped, Philadelphia, Pa. 116 pages.

A LOOK AT THE CHILD. (ED084738) Association for Education of the Visually Handicapped, Philadelphia, Pa. 232 pages.

THE COMPUTER BASED PROJECT FOR THE EVALUATION OF MEDIA FOR THE HANDICAPPED. SUMMARY OF RESEARCH, 1969-1972 (ED084739) Syracuse City School District, N.Y. 57 pages.

THE RIGHTS OF THE MENTALLY HANDICAPPED. (ED084744) National Association of Coordinators of State Programs for the Mentally Retarded, Arlington Va.; Washington State Dept. of Social and Health Services, Olympia. Office of Developmental Disabilities. 118 pages.

DEVELOPING ART EXPERIENCES FOR THE EMOTIONALLY HANDICAPPED CHILD. (ED083762) New York City Board of Education, Brooklyn, N.Y. Office of Special Education and Pupil Personnel Services; New York State Education Dept., Albany. Div. for Handicapped Children. 53 pages.

A COMPARISON OF THREE METHODS OF PHYSICAL EDUCATION PROGRAMMING FOR EMOTIONALLY DISTURBED CHILDREN. FINAL REPORT. (ED083776) Office of Education (HEW), Washington, D.C. 320 pages.

ACTION GUIDELINES: EVALUATING AND MONITORING EDUCATION SERVICES FOR MENTALLY RETARDED PERSONS. (ED083777) National Association for Mentally Retarded Children, Arlington, Tex. South Central Regional Office. 34 pages.

PHYSICAL EDUCATION FOR HANDICAPPED CHILDREN AND YOUTH. (ED083778) Ithaca Coll., N.Y. School of Health, Physical Education, and Recreation. 173 pages.

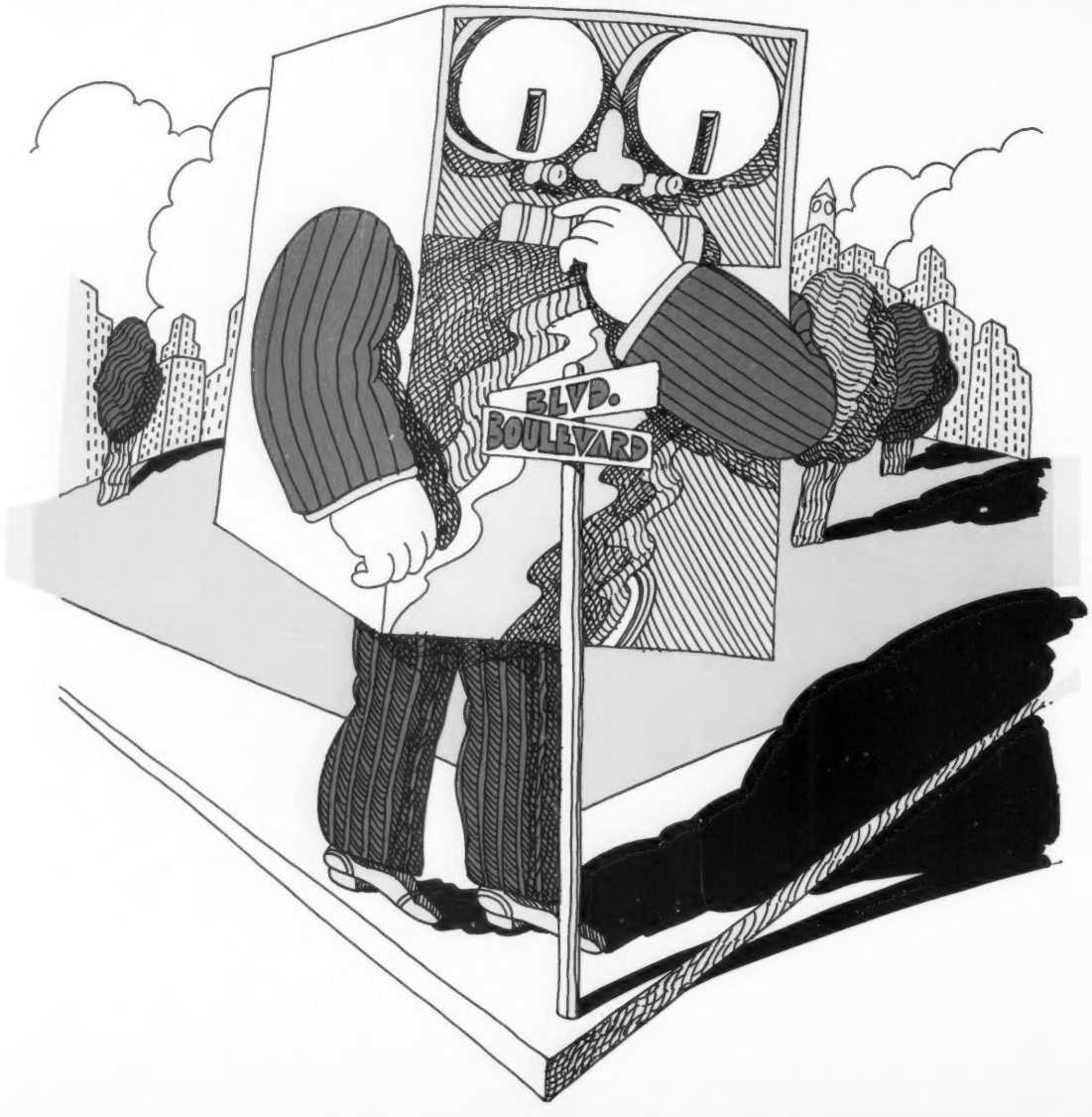
WHAT IS EFFECTIVE PROGRAMMING FOR DEAF-BLIND CHILDREN? (ED084730) Callier Hearing and Speech Center, Dallas, Tex. 15 pages.

AFFECTIVE REACTIONS IN SOME PARENTS OF DEAF-BLIND CHILDREN. (ED084731) Callier Hearing and Speech Center, Dallas, Tex. 13 pages.

BOOKS FOR MENTALLY RETARDED CHILDREN. (ED084749) Cincinnati-Hamilton County Public Library, Ohio. 35 pages.

PHYSICAL ACTIVITIES FOR HANDICAPPED CHILDREN IN THE HOME. (ED084753) Iowa Univ., Iowa City. Univ. Hospital School. 77 pages.

How the Computer Works



The following is reprinted with permission from *American Medical News,* Vol. 16, No. 44, November 12, 1973.

It has become almost impossible for the average person to go through an entire day without encountering the work of a computer. Yet few of us really understand how a computer works. And many of us still regard computers with a measure of suspicion.

After all, computers these days are doing some pretty mind-boggling things. They talk, they play chess, they warn our astronauts whenever some little thing in a spaceship goes out of whack. And there's a computer up in Vermont that seems to "think" like a physician. No question about it, computers have come a long way since German mathematician Gottfried Leibniz built the first desk calculator back in 1693.

Experts assure us that behind the switches, buttons, and lights, computers are basically simple machines. And the experts have created a number of analogous comparisons to illustrate their point.

One of the cleverest of these illustrations is the "little man" analogy offered by mathematician David Hill, Ph.D., an executive vice president for Geomet, Inc., a data systems and processing outfit based in Maryland. Dr. Hill says he borrowed the idea for his analogy from the late Alan M. Turing, the man who theorized about complex machine computation before it ever became complex. Dr. Hill's illustration, however, is considerably embellished.

"Picture a little man sitting at a desk. He's got a desk calculator, a telephone, a pencil, a yellow legal pad, and he has access to a library. He can add, subtract, multiply, and divide, and he is capable of making two-value data base judgments: yes-no, do-don't, start-stop, and so on.

"The man takes orders over the telephone. He writes his instructions out on the yellow legal pad.

"Now people are always asking, Can the computer do such-and-such? Well, if the man with the desk calculator and the library can do it, the computer can do it. From that, you can judge for yourself the impact of the computer.

"Let's take an example of how the man with the desk calculator functions. We'll say you want to find out if a certain car is a stolen car. You give the man the license number, tell him to go into the library and get the file of license numbers on all cars reported stolen.

"Tell him to subtract the number you just gave him from the first number in his library file. If the answer is zero, the response is 'Call the cops.' If the answer is not zero, go on to the next number in the file."

H. A. (Hank) Daughtry, Jr., executive vice president of the San Antonio-based data processing firm COMPAS, Inc., gives us some additional insights about our man-computer. "What most people don't understand," he says, "is how literal a computer is. It is a literal idiot."

In other words, if we give a human being two street addresses—"103 Windsor Blvd." and "103 Windsor Boulevard"—he'll quickly guess that the two addresses are the same. But not the little man with the desk calculator. Unless he is specifically told that "Blvd." and "Boulevard" refer to the same thing he is too literal to recognize the obvious.

The biggest difference between the little man and a real computer is speed and the ability to perform multiple functions. Dr. Hill asks laymen to imagine themselves stranded on a tropical island where the native population thinks and speaks at a rate no greater than one word per minute.

It would be relatively simple, he says, for the newcomer to gather 12 or 15 natives in a group and answer questions from all of them simultaneously by moving around the group, taking notes as each native speaks his minute's worth.

"They'd think you were the greatest thing that ever hit their island."

In reality, computer speeds surpass comprehension. Back in the 1940's, speed was measured in tens of operations per second. In the late 1950's computers were capable of hundreds of thousands of operations per second. Speeds since then have been multiplied by as much as 1,000.

And the National Aeronautics and Space Administration's Illiac IV, largest computer in the world (at press time), is designed to execute up to 150,000,000 instructions per second. When fully operational, the $30 million computer will provide full-time employment for up to 300 programers.

Interdisciplinary Management of Developmental Disabilities Cases

WILLIAM HOWARD

Danny Green had become more than just a difficult pupil in the fourth grade. Where formerly he had sat sullenly at his desk ignoring his classwork, the boy's behavior now had changed to one of frequent emotional outbursts.

He would suddenly scream incoherently at the teacher. Again, he might fling a book across the room or, without provocation, begin pummeling the child next to him. One day he jabbed a classmate in the hand with scissors and the teacher had had enough.

Because Danny was reading at barely the first-grade level and had great difficulty articulating even short sentences, the teacher suspected he was mentally retarded. That tentative diagnosis was passed along to the school physician who, after an examination of the boy, concurred that he was unfit to remain in school.

The question now was what to do with the youngster. Danny's mother was on public assistance and hardly able to care adequately for three younger children. An older daughter with disturbed behavior like Danny's previously had been institutionalized as retarded.

The social worker in the case believed that both Danny's and his sister's problems were probably more psychological in nature than genetic because their father, an alcoholic, had committed suicide. But the social worker lacked the training and knowledge to deal with doctors, diagnostic services, community agencies, and the courts in order to obtain the therapy and special education that might have helped the youngster overcome his handicap. As a result, Danny was placed in an institution for the mentally retarded.

The disposition of Danny Green's case (that is not the boy's real name) is fairly typical of many of the thousands of "retarded" children who are sent to institutions every year. The case also is a typical illustration of what HEW's Division of Developmental Disabilities is trying to prevent under its University-Affiliated Facilities (UAF) program.

Simply put, the UAF program is aimed at providing the manpower to care for the retarded and those with other developmental disabilities within the community, to help them lead useful lives, and not ship them off to the limbo of an institution or allow them to atrophy in the family attic.

The watchword of UAF is interdisciplinary—the cross-training of professionals and paraprofessionals in the field so they will work together in the community as a team to diagnose a child's problem and provide the most effective treatment.

Currently, in 34 UAF programs across the Nation more than 52,000 students ranging from college undergraduates to post-doctoral specialists are receiving interdisciplinary training at 14 levels of instruction. They include students in pediatrics, general medicine, psychiatry, dentistry, nursing, special education, social work, and administration. UAF officials also are encouraging law students and the legal profession to enter the program to provoke greater awareness of the ethical and moral questions surrounding the care of the developmentally disabled.

The philosophy of the program is directed not only at familiarizing various specialists with one another's roles, but also to "democratize" decisionmaking in individual cases so the person specializing in the child's greatest problem takes the major role in the management of the treatment program.

Traditionally, management of developmental disability cases has fallen to physicians even though the majority of disabilities are not medical in nature. Of the 6 million Americans classed as mentally retarded, an estimated 10 to 25 percent have medical problems. The great majority mainly need special education and occupational training.

By the nature of their work and training, UAF officials say doctors may not be well equipped to deal with nonmedical cases. Most doctors work alone or with other doctors. As a result, they may be only vaguely aware, for example, of what a psychologist specializing in emotionally disturbed children could do for a Danny Green. Many doctors are not conversant with the new techniques of the speech therapist and the reading laboratory specialist assisting the dyslexic child. And very few know what a social worker does, or that 15 percent of the Nation's welfare

caseload involves retarded persons.

Hence, the UAF program is heavily weighted toward enlightenment of the

medical profession. "Quite frankly," says one UAF official, "we feel the payoff for this program is in getting to doctors and pediatricians while they are in the training process to appreciate that a well-trained specialist, be it in education, social work or whatever, may be just as or even more valuable than a doctor in overcoming a child's handicap."

Training at the UAF centers takes place in a clinical setting. There are approximately 20,000 client-patients, allowing trainees to cope directly with the handicapped. Program officials view this as particularly useful for doctors and dentists, many of whom may not be aware of the mentally retarded's special needs.

There is, in fact, a shortage of dentists who will treat the retarded. Recently, in an unusual professional change of direction, a pediatrician at Children's Hospital in Boston, Massachusetts, responded to this problem by being trained as a dentist.

The interdisciplinary approach is expected to yield new techniques in aiding the handicapped and some are already being tried. Again at Children's Hospital, a vocational rehabilitation program is underway with youngsters 3 years old and above. Started by William E. Kiernan, the program is aimed at helping the children's parents develop realistic long range occupational expectations for their offspring and to inculcate in the youngsters habits which will have vocational utility later on.

Training of retarded children with handicaps usually stops with getting them to dress, feed, go to the toilet and handle other daily needs along with whatever education they can absorb. But ways have been developed for giving very young children experience in assuming responsibility for various chores to prepare them for adult work later on. The idea is to build in a work component in the child's training as soon as he can grasp it and to teach parents to think of these children as growing into useful adulthood.

UAF promises to have a long range impact on the financing and administration of programs for the handicapped. Presently some 200,000 persons, or 4 percent of the mentally retarded, are institutionalized. Hopefully, UAF will substantially help reduce the high cost of patient maintenance.

Authorities say many of those in institutions should not be there, and there are many who should be institutionalized who are not. UAF hopes to provide an important portion of the specialized manpower to screen patients in institutions and determine which patients can be released for training and treatment in the community. Similarly the screening will be done in the community to assure that only those who require it are institutionalized.

In time, this could result in a major reshaping of State programs for the handicapped. It may be possible to place more emphasis on special education and vocational rehabilitation and to diminish the reliance on institutional care.

UAF officials believe that, with a growing supply of skilled manpower plus imaginative use of that manpower by community agencies, it will be possible to place more handicapped children back in their own homes, or in foster homes, or, in the case of adolescents, in homes in the community specializing in group care. The latter is a relatively new idea and generally handles groups of 10 to 15 young adults who have just come out of institutions.

The UAF program today is being directed more and more toward community involvement. Officials are exploring how the individual programs at 34 UAFs can be tied more closely to State planning and advisory councils for developmental disabilities and various agencies at the city and State level.

The UAF program began a decade ago, the result of a recommendation by the President's Panel on Mental Retardation in 1962. The panel underscored the importance of training a variety of professionals of different disciplines together in clinical settings where they could learn advanced practices in serving mentally retarded persons and their families. The President's panel also urged the cultivation of cooperation and coordination between universities and States to identify and meet the manpower needs of the field.

During the 1960s the UAF program erected 26 buildings on university campuses to house program facilities. The Federal Government through HEW's Maternal and Child Health Service has supported training for professional personnel for health and service operations related to care of children at many of the UAF centers. Currently, UAFs are expanding the training aspect of the program to include community and junior colleges so as to include the training of paraprofessionals in the developmental disabilities field.

Only a few of the UAF centers have been operational more than 2 or 3 years, and many are just beginning. The program thus is still fluid and the full potential of any one center remains to be demonstrated in terms of training and service.

However, there are indications that the people who have already been trained in the programs have found the experience rewarding. A followup study of 117 trainees at the University of Tennessee Child Development Center, Memphis, in 1972 revealed that 71 percent were then involved in work with developmentally disabled children and 81 percent of the trainees reported that their training was a significant factor in their present position.

Most importantly, the survey showed that trainees who had a year of training were likely to assume a leadership position. Most of those who fell into this category were either directors of programs or directors of specific parts of bigger programs.

The shorter the training time, the more likely trainees were to be found in private practice, teaching in colleges and universities, and working in clinics and public schools.

The overall conclusion of the survey was that long term UAF training is effective in providing leaders for the field.

Thus the UAF program is furthering the achievement of the President's goals of a 50 percent reduction in the incidence of mental retardation by the end of the century and to reduce the number of persons in mental retardation institutions by one-third.

Mr. Howard is a freelance writer.

Publications and Films

The Editors of the SOCIAL AND REHABILITATION RECORD regularly receive notification of the release of new publications and films of interest to readers.

Each issue of the RECORD will carry a selected list of these publications and films with brief discriptions of their contents.

Please address all inquiries and requests to the addresses given in this listing.

Measurement of Outcomes. Research and Training Center, West Virginia University, Institute, West Virginia 25112. 100 pages.

The Institute on Rehabilitation Issues held its first annual meeting in Denver in April 1974. Composed of three study groups (on the severely disabled, measurement of outcomes, and appraisal of counselor performance), this is the report of the second group's deliberations.

The report considers the problem at hand by defining it, reviewing the group's charges relating to the problem, and defining terms. In that context, the report looks into legislation and reviews and analyzes current practice. In its final chapter, the report presents conclusions and recommendations, including presentations on alternatives to closures (weighted systems and modifications of closure statuses) and minimal acceptable standards in measurement of outcomes.

Interpreters' Services and the Role of Health Care Volunteers. American Hospital Association, 840 North Lake Shore Dr., Chicago, Ill. 60611. 35 pages. $1.75.

The value of interpreters and volunteers in a health care situation is examined in this publication. Recognizing that total hospital coverage considers both psychological and physical demands, the American Hospital Association uses this opportunity to review the interpreter needs of foreign, hearing and visually impaired patients.

In addition to examining the services and roles of interpreters and volunteers, the booklet offers specific guidelines for planning and implementation of such services in a hospital.

Therapeutic Needs of the Family. Richard E. Hardy, Ed.D. and John G. Cull, Ph.D., editors. Charles C Thomas, 301-327 East Lawrence Ave., Springfield, Ill. 62703. 240 pages. $11.75.

The pressures and demands of a modern technological world affect not only society as a whole, but also its integral units such as the family. Because the increased stress often pulls the family tradition apart, there is a growing need for therapeutic and counseling methods to knit it back together.

This collection of articles explores the major causes of family crisis and presents guidelines for counseling techniques. The articles examine the following areas: group work with distressed families, family crisis intervention, the child of divorce, prediction of delinquent behavior, counseling the parent of the chronic delinquent, psychological management of the family and the dying child, separation counseling, alternatives to divorce and their implications, and orgasmic problems.

Teaching The Mentally Handicapped Child. Ralph Hyatt, Ed.D. and Norma Rolnick, Ph.D., editors. Behavioral Publications, 72 Fifth Ave., New York, N.Y. 10011. 337 pages. $12.95.

A textbook for professionals and students concerned with the education of children who are mentally retarded, emotionally disturbed, and neurologically impaired, this publication offers guidelines in child development theory and practice.

The authors explore the following areas: general research and child development theory, the neurologically based pediatrician and deviant development, behavior modification, the acquisition of language, and psychoeducational evaluation. Also included are special education classroom techniques in movement therapy, teaching methods for the multiply handicapped child, and a Piagetian approach to mathematics teaching.

Handtalk: An ABC of Finger Spelling & Sign Language. Remy Charlip, Mary Beth and George Ancona. Parents' Magazine Press, 52 Vanderbilt Ave., New York, N.Y. 10017. $4.95 (trade edition), $4.89 (library edition).

"In a very ugly village, near a very ugly valley, under a very ugly volcano, lived a very ugly vampire, with his beautiful vulture. . . ." Imagine the possibilities for this story as it unfolds in the form of words, hand gestures, or facial expressions! This innovative "picture book" demonstrates these varied options of story telling and communication produced by finger spelling and signing.

The set of color photographs which make up this book accompany the finger spelling alphabet with illustrative words or phrases. The words are "spelled out" both in the expressive signing action and in the combination of finger spelling letters.

Designed for children as an introduction to the sign language used by deaf persons, this book helps them learn the alphabet, word concepts, and basic sentence structure. The book's appeal, however, reaches out to all ages. The unidentified words, which urge the reader to find the meaning from the alphabet or from the portrayed action, and imaginative photography stimulate a general enthusiasm and a desire to learn more about this practical and poetic, nonverbal means of communication.

Adolescent Patients in Transition: Impact and Outcome of Psychiatric Hospitalization. Mollie C. Grob, M.S., and Judith E. Singer, Ph.D. Behavioral Publications, 72 Fifth Ave., New York, N.Y. 10011. 202 pages. $9.95.

The need for improved, comprehensive psychiatric treatment of adolescents has been recognized and implemented in many hospital centers throughout the country. During the last decade, the Mclean Hospital in Belmont, Massachusetts, has been a leading institution in the development of a hospitalization program for disturbed youth that includes treatment in a residential and educational environment. This book represents a continuing research and evaluative effort which examines the Mclean Hospital program.

The clinical profiles of patients are considered here in conjunction with descriptions of parents' roles, hospitalization treatment, followup interviews, family reactions, and a comparative look at adolescent patients entering the psychiatric center during the 1970's.

The Rehabilitation Medicine Services. Laurence P. Ince, Ph.D. Charles C Thomas, 301-327 East Lawrence Ave., Springfield, Ill. 62703. 576 pages. $22.50.

The effective coordination of medical and social services is an essential factor in the rehabilitation of a disabled child or adult. This publication examines the following areas of that process: physical therapy, occupational therapy, speech and language therapy and auditory train-

ing, psychology, social work, vocational counseling, recreational therapy, and nursing.

The inclusion of updated references and the brief descriptions of rehabilitation patient disorders and handicaps further establish this book as a general text for students, new health workers, and professionals who are entering or seeking to become better acquainted with the rehabilitation field.

Electronic Communication With Deaf and Deaf-Blind Persons. Jerome D. Schein, Ph.D., editor. Deafness Research and Training Center, New York University, 80 Washington Square East, New York, N.Y. 10003. 30 pages.

Recognizing the need for research in the area of distance contact with persons who are deaf and deaf-blind, the N.Y.U. Deafness Research & Training Center and the National Center for Deaf-Blind Youth and Adults collaborated on a study of a portable vibrator signal system. The results of field tests in home and industrial settings, engineering and performance testing, the suggested improvements, and overall evaluation of this means of communication are presented in this monograph.

Films

A Family Album. Color. 18 min. Aetna Life & Casualty, 151 Farmington Ave., Hartford, Conn. 06115. Free loan basis.

A close look at a "real-life" family situation following a recent divorce reveals the importance of open communication in the handling of problems and relationships both before and after the breakup. Presented as a discussion provoking tool, this film may be useful in family therapy sessions.

Out Of Left Field. 16mm. Color. 6-1/2 min. American Foundation for the Blind, 15 West 6th St., New York, N.Y. 10011. Rental cost is $1.50 per screening plus a handling fee of $4.50 for each shipment.

A series of workshops examining the problems and possibilities of programs to integrate blind and visually impaired youths into community recreational and social activities were recently conducted by the American Foundation for the Blind. This film presents a summary of the substance and findings of those meetings.

The following films and videocassettes are available from National Instructional Television Center, Box A, Bloomington, Ind. 47401. Each film is in color, is 15 minutes long, and may be purchased for $150 (film) or $125 (videocassette). The films are part of an "Inside/Out" series designed by health educators and learning specialists to help 8- to 10-year olds to better understand their emotions.

Breakup. In this film, a child's emotions and concerns regarding the parents' separation or divorce are sorted out in terms of Becky's apprehensive situation.

Home Sweet Home. Two young boys who feel that the world, and especially their parents are against them decide to run away. Their feelings of mistreatment, found in most children, are explored in this sequence.

Living With Love. The effects and expressions of love are demonstrated in this documentary concerning Mrs. Dorothy Smith and the affection she gives to children living in her foster care.

A Far Cry From Yesterday. 16mm., 8mm., and video-cassette. Color. 20 min. Perennial Education, Inc., 1825 Willow Rd., P.O. Box 236, Northfield, Ill. 60093. Sale, $275. Rental, $28.

A Planned Parenthood produced educational film, *A Far Cry From Yesterday* is a frank account of an unmarried couple who accept an unplanned pregnancy and decide to keep the baby. Laura and Jason appear ignorant, however, of the practical demands incurred by a newborn child. Once the child is born, their lack of foresight is revealed as a damaging influence on their loving relationship.

Cast No Shadow. 16mm. Color. 27 min. Professional Arts, Inc., Box 8484, Universal City, Calif.

Emphasis is on values of recreation and its effects upon lives of handicapped persons as an integral part of their total learning experiences and social development. Equally, it is about handicapped individuals, ages 2 to 85, as people.

Coming Home. Color. 28 min. PARC, 127 Locust St., Harrisburg, Pa. 17101. Sale, $200. Rental, $15.

This film describes how Charlotte, an 18-year-old, leaves a State school for a group home, which becomes a focus of neighborhood fears.

America On The Rocks. Color. 28 min. National Audiovisual Center, Washington, D.C. 20409. Sale, $113.50. Rental, $12.50. (Also available in a 15-minute version. Sale, $72. Rental, $10.)

The growth of alcoholism among middle class Americans is documented in this educational film produced for the National Institute on Alcohol Abuse and Alcoholism. Not only are the middle class drinking habits carefully exposed, but the damaging effects of heavy "social" drinking are viewed in terms of breaking down traditional family order.

Task Analysis: How To Use The National Task Bank. Sample package of training materials available from the W. E. Upjohn Institute for Employment Research, 1101 17th St., N.W., Suite 905, Washington, D.C. 20036. Sale, $5.

An audio-visual training package is now available to users of the National Task Bank. The trainer's materials include eight 35mm., color filmstrips and audio cassettes (automatic or manual), two audio cassettes, one manual (loose leaf, display binder), one scriptbook, four wall charts, one set of participant's materials. These items are reuseable.

Participants' materials include loose leaf workbooks, "An Introduction To Functional Job Analysis . . . ," "Functional Job Analysis Scales: A Desk Aid," and Training Task Banks for 20 participants.

And The Walls Came Tumblin' Down. Color. 25 min. St. Elizabeths Hospital, Interlibrary Loan, Washington, D.C. 20032. Free/Loan.

This documentary on the mental health program for the deaf at St. Elizabeth in Washington, D.C., features trained professionals demonstrating various treatment approaches for dealing with the emotional problems of the deaf, including individual psychotherapy, group therapy, psychodrama, and occupational therapy.

Also shown are activities in a clinic in speech pathology and a comprehensive program for vocational rehabilitation.

With all of the activities, the goal is to alleviate the deaf person's greatest problem—isolation.

Individualizing Rehab Plans for Cost-Effective Gains

ANTHONY S. DESIMONE

Tom is 36 years old. This morning he made and packed his lunch and, with lunch box tucked under his arm, he left his boarding house for work at a local gas station. Even though he reaches his destination a half hour before starting time, he grabs a broom and sweeps the grease-collecting sand between the service bays. He greets his boss and coworkers as they arrive.

Anyone can invent that scene because it's pretty representational. What makes it different in Tom's case? Only this: Tom has spent the first 35 years of his life in a State institution for the mentally retarded. He was placed there by his parents. As the years went by, he developed a serious visual problem. Now blindness added to his problem of retardation. He was a "total care" case.

But the scene changed when a new and dynamic rehabilitation-supported habilitation program was introduced at the institution. The project demonstrated that with a comprehensive diagnostic evaluation, leading to a specific plan of services and the provision of expert habilitation programs, Tom's potential, hidden for so long under the warehouse concept, could flower.

With mobility training, he learned to take care of himself, to become independent in daily living activities. With training in good work habits and a brief, supervised exposure to community living, Tom changed his institutional address for his own personal and private residence.

It cost the State $10,000 for *each* of the 35 years he spent at the old address. But Tom is now helping to pay some of that back in taxes on his earnings.[1]

Most institutions do not have goal oriented systems for their residents. My exposure to the multifaceted problems indigenous to residential institutions for the retarded has given me the opportunity to view first hand the many obstacles that face institutional management. We have long ago past the crisis stage in the need to change the nonsystems from custodial care to accountable habilitation systems that are concerned with individual patient objectives.

It would be presumptuous of me to review the growth and development of residential institutions. The historical perspectives are well known. Current attitudes are reflected in MR literature. Essentially these attitudes can be paraphrased as "out of sight, out of mind," "It's the States' responsibility," "overcrowding and lack of staff," "Dehumanization and crisis reaction," "Deinstitutionalization to

small community-based facilities, community facilities, and back to custodial care."

In an enlightened age of patient management systems, the institutions have changed very little. There are some isolated exceptions, but, in general, most States still have their Willowbrooks or modified versions of them. This is not to suggest that new methods and techniques have not been utilized in some institutions. Indeed, vocational rehabilitation, mental retardation, and developmental disability funds have supported specific projects, such as behavior modification, habilitation of blind retardates, and comprehensive diagnostic evaluation techniques. But these projects have not been readily absorbed or placed within the system. In some instances, they gradually have been eliminated after federal funding was terminated.

A variety of new ideas and methods are available to the institutional manager.[2] These ideas and methods were treated independently in the Stevens presentation. Consequently, one can be misled into thinking that the parts are not related to the whole-patient concept. While my reference is 5 years old, I am willing to be corrected if, indeed, there is a significant number of residential institutions that have integrated the medical, psychological, social, and vocational subsystems into a goal oriented, patient centered system.

Let us for a moment look at the institution as a business enterprise, complete with a profit and loss statement and an end product. Is this a farfetched idea? I think not. In 1968, Mr. Alton Marshall, then Secretary to the Governor of New York, said to the New York State Mental Retardation Assembly that "Good government also means regard for cost effectiveness or where will a dollar spent do the most good." Well, what's new about that? What has it to do with goal oriented plans? Answering the questions with a question: How many institutional managers can identify what each dollar has been spent for and to what benefit for each individual resident?

From my experience and from other sources of information, I believe that an answer would be impossible from almost every institution. It is actually not possible to determine what it has cost the public to provide John Jones with X, Y, and Z services and also to determine what have been the results of these expenditures. If this is true, and it is the case apparently, how then can the institutional manager tell whether staff and services are effective and whether the dollars are being spent appropriately?

Operational Philosophy and Practice

There is a need to develop an institution wide operational philosophy based on habilitation rather than custodial care. This is critical to implementing a goal oriented system. It should be understood by *every* individual in the institution.

The development of patient goals derives from careful, individual, and comprehensive diagnostic evaluations. Such evaluations should have both short term and long term goals. They should establish the individual's basic limitations as well as capacities. They provide a baseline from which growth and development can be measured and against which the effectiveness of services provided can be measured.

Patient goals may vary according to such factors as age, functional limitations, and available resources. For some, the achievement of a stable life support system may be a goal. For others it may consist of partial or complete independent living that may be institutional or community based. And for still others, the goal may be expressed as partial or independent full-time employment in the community.

In each and every case, it is possible to develop a profit and loss statement or a cost benefit ratio when case cost records are attached to the chronological case records. This provides a management tool for assessing individual patient change and the costs necessary to achieve it. Since the case manager is responsible for individual clients, he should be held accountable for the achievement of the plan of services. It is his responsibility to see that the client receives the services that he needs and are in the client plan. In this sense, the case manager may be called a client advocate.

The case record itself is a critical instrument in the service delivery system. As a management tool, it becomes an ongoing assessment of a patient's progress towards the achievement of goals.

Change by Fiscal Accountability

It seems ironic that changes in patient care systems are seemingly based on fiscal accountability rather than on patient needs. The thrust to individual patient care is evident under

the new intermediate care facility regulations.

Qualified MR professionals must be responsible for supervising the implementation of each resident's plan of care and service. This allows for integrating various aspects of institution programs and initiating periodic review of individual plans of care and service. Furthermore, each State will have the responsibility under Medicaid for monitoring and evaluating Medicaid expenditures. They will be required to have access to individual case cost information to determine appropriate utilization of federal and State funds.

Computerizing the System

Still in the developmental stage is a fascinating project designed to cope with the Willowbrook crisis which we hope will be responsive to improving the management of all institutions. More importantly, it will implement a goal oriented service system that is tailored to individual patient needs. The Rehabilitation Services Administration and the Medical Services Administration have been working with the New York State Department of Mental Hygiene on a computer system that would insure the following:

- A more effective way of monitoring the provision of services or lack of services to patients;
- A statistical information system which will comply with intermediate care facility and nursing home legal standards and, at the same time, provide insight into the various methods used for habilitation and their effectiveness; and
- A development of a potential goal oriented path for each client, while maintaining legally required standards for record keeping. Included in this concept would be constant monitoring of client's success with therapy, drugs, etc.

It may sound like the year 2001 but the best effect of such a computer-based system would provide, at the touch of a button, either on a readout TV tube or in a computer printout, such items as:

- Necessary patient data, program components, medical and service records, and other reports;
- Report on the comprehensive diagnostic evaluation;
- The individual services plan with objectives for each discipline to achieve and the time frame for achievement;
- Milestones and action step data;
- Case/client management, accountability for client services and cost-benefit evaluation related to individual client treatment plans and goals;
- Costs per service per patient;
- Followup in the community for those residents whose goal is community placement;
- Effective methods for accounting for the expenditure of federal and State moneys in the provision of Medicaid and other services;
- Call attention to services that have not been provided by a certain date, as originally programed; and
- Provide research data on drugs, therapy, etc., the amount used by whom and to what effect.

Is the computer the solution to the warehousing of patients? I hardly think so. It is a management tool to convert the warehousing approach to one accenting habilitation.

The keystone to any radical institutional change lies in the attitude of staff from the aide to the administrator and every level in between. Indeed, if the habilitation philosophy is not clearly articulated and understood by all, there is no hope for achieving the goals of any project, whether it be computer based or not.

I firmly believe that we are on the brink of major changes in institutional systems. These changes will be brought about not only by professional concern and advocacy but by effective management and economic constraints for the accountability of massive expenditures of public funds.

I also believe that we must use this opportunity to improve our service system to reflect the very best of new knowledge. We must convert now the rhetoric that has appeared in past proceedings of seminars and conferences to the reality of daily operations.

Mr. DeSimone is Associate Regional Commissioner for Rehabilitation Services, Region II. This article is based on a paper he presented at a Mental Retardation Institute, N.Y. Medical College, Valhalia, N.Y.

Notes and References

1) The name and incident reported here is altered to protect the confidentiality of the case. Otherwise the incidents reported are factual.

2) Stevens, Harvey A. "Residential Care—The State of the Art." article in proceedings of a Conference on Residential Care, June 13-14, 1968. University of Hartford. Sponsored by SRS and the University of Hartford.

Sign up for 'Signing'

"Signing" is one of the principal ways deaf persons communicate.
If you can learn the language of signs, you can speak with most persons with long standing severe hearing problems and help end isolation and broaden their horizons. And your own.
Often persons with hearing problems do not know about basic services within reach in their community because of the inability of most social workers to communicate with them.
To obtain information about courses on signing in your area, contact a local vocational rehabilitation office, a club or school for the deaf, or a hearing and speech agency.

The Administrative File

Each month the SOCIAL AND REHABILITATION RECORD will carry a listing of SRS administrative issuances for previous months. Over the course of a year, the RECORD will have presented a complete bibliography of administrative issuances for the year.

The following are the administrative issuances for the months of September and October 1974. (Abbreviations key: **PR**-Program Regulations; **PRG**-Program Regulations Guides; **PI**-Program Instructions; **IM**-Information Memoranda; **FSI**-Field Staff Information and Instruction Series; **AO**-Administrator's Office; **MSA**-Medical Services Administration; **APA**-Assistance Payments Administration; **CSA**-Community Services Administration; **RSA**-Rehabilitation Services Administration; **NCSS**-National Center for Social Statistics.

When ordering reports, please specify the appropriate room number for the particular report: For NCSS reports, room 2620; AO reports, room G-115B; RSA reports, room 3126; APA reports, room 1232E; MSA reports, room 4094; and CSA reports, room 2010.

Send all requests with the appropriate room number to Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, 330 C Street S.W., Washington, D.C. 20201.

AO-IM-75-6: Limitation on Federal participation for Capital Expenditures (9/9/74)

AO-IM-75-7: Suspension of Phase-out of Cuban Refugee Program (9/24/74)

AO-IM-75-8: Addition to the Compilation (9/20/74)

AO-IM-75-9: Imposition of Interim Limits of Entitlement WIN (9/24/74)

AO-IM-75-10: WIN REDESIGN (9/19/74)

AO-PR-20-12: Definition of Incapacity (9/23/74)

AO-PR-20-7(C-11): Need and Amount of Assistance — Pass on of OASDI increases Not Required. AMENDMENT (9/26/74)

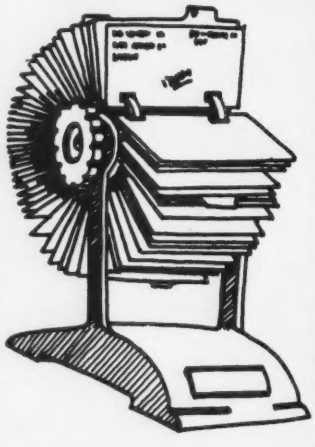
AO-PR-10-9(C-3), 201.1, 201.3 201.6; 1-3(C-1), 204.1; 10-11(C-22), 205.30, 205.50, 205.60; 10-10(C-2), 205.70; 10-16(C-1), 205.100; 10-17 (C-2), 205.101; 10-11(C-22), 205.130, 205.145, 205.150, 205.190, 205.200; 10-4(C-1), 225.2, 225.3: Title IV Modifications (9/26/74)

AO-PR-40-9(C-1): Discharge Planning (10/3/74)

APA-PI-75-6: Release of Data on AFDC Recipients in Relation to Title I of the Elementary and Secondary Act (9/6/74)

APA-PI-75-7: State Information Exchange Items (9/20/74)

APA-IM-75-3: AFDC Consolidation Guidelines (9/10/74)



APA-IM-75-4: How-They-Do-It: Local Supervisory Review of Case Actions—The New Mexico Systems (9/19/74)

APA-IM-75-5: How-They-Do-It: Photo ID Card System for Welfare Recipients (9/23/74)

CSA-IM-75-1: Report to Congress on Services to AFDC Families (9/16/74)

MSA-IM-75-4: Payments to States — Promulgation of Federal Percentage and Federal Medical Assistance Percentage (9/16/74)

MSA-IM-75-5: Correction of Revised Copies of Title XIX Necessitated by Enactment of P.L. 93-368 (9/24/74)

MSA-IM-75-6: Postponement of Seventh Annual Conference of State Medicaid Directors (9/26/74)

MSA-PIM-75-4: SNF Participation in Medicare as a Condition for Participation in Medicaid (9/24/74)

MSA-PRG-33: Maintenance of Effort for Intermediate Care Facility Services in Public Institutions for the Mentally Retarded (9/30/74)

MSA-FSI-75-7: Free Choice of Qualified Provider (9/3/74)

MSA-FSI-75-8: Federal Percentage and Federal Medical Assistance Percentage (9/6/74)

MSA-FSI-75-9: PSRO Reprint from the SRS *Record,* June 1974 (9/18/74)

MSA-FSI-75-10: Technical and Actuarial Assistance to States Contracting with HMOs for Services to Title XIX Recipients (9/24/74)

MSA-FSI-75-11: Postponement of Seventh Annual Conference of State Medicaid Directors (9/26/74)

RSA-PI-75-7: Vocational Rehabilitation Program Under Supplemental Security Income (SSI) Provisions of the Social Security Act (9/13/74)

RSA-PI-75-8: Estimated Allotment for the VR Basic Support Program Under Section 110 of the Rehabilitation Act of 1973 for Fiscal Year 1975 (9/30/74)

RSA-PI-75-9: Estimated Federal Grants for States Under the Beneficiary Rehabilitation Program (Trust Funds) for Fiscal Year 1975 (9/30/74)

RSA-PI-10: Vocational Rehabilitation Program Under the Supplemental Security Income (SSI) Provision of the Social Security Act for Fiscal Year 1975 (9/30/74)

RSA-IM-75-17: Number of Severely Disabled Persons Rehabilitated by State Vocational Rehabilitation Agencies July 1, 1973 to June 30, 1974 (9/9/74)

RSA-IM-75-18: Number of Rehabilitations: July 1 to June 30, Fiscal Years 1973 and 1974 (9/9/74)

RSA-IM-19: Distribution of "A Profile of Sheltered Workshop Workers Rehabilitated During Fiscal Year 1972" (9/13/74)

RSA-IM-75-20: GAO Audit of Vocational Rehabilitation Program Paid from Social Security Trust Funds (9/17/74)

Utilization Control in Medicaid

IZANNE LEONARD

After work on Friday evening, Mary Moore entered the hospital for routine tests that were scheduled to begin Monday. Her physician had not ordered a special diet nor had he directed hospital or medical services to be started until Monday morning.

By early March, John Doe had recovered sufficiently from an acute illness. He no longer needed 24-hour nursing supervision. But he did need more than room and board. Yet, in August, almost 6 months later, he was still paying for skilled nursing care at $20 per day when he could have been paying $13 for the intermediate level care commensurate to his needs.

The above situations occasion several questions: Why waste Mary's weekend and cause her additional expense? Why should John pay $20 a day for skilled nursing when $13 would suffice? As the demand for hospital beds, the concern for quality care, and the costs of medical care skyrocket, questions such as these crop up increasingly. The 1972 Social Security Act Amendments responded to these concerns by establishing broadscale controls over utilization of institutional health services paid for under the Medicaid program, or utilization control (UC).

But UC history dates back to Florence Nightingale's efforts in the 2nd half of the 19th Century to improve utilization of services for Crimean war soldiers and for the English poor. More recent and familiar examples are found in various quality control committees in hospitals, such as the tissue, blood, medical audit, and medical records committees. All have existed for some time. Also, in 1964, the American Medical Association's House of Delegates acknowledged the growing need for controls on service utilization by promoting major physician responsibility for reviewing utilization and quality controls. It sponsored its first National Conference on Utilization Review in November 1965.

Formal interest in the control of utilization of services under Medicaid (Title XIX of the Social Security Act) can be traced to the 1967 Amendments of the Social Security Act. In section 1902 (a)(30), Congress expressed its concern over utilization review by requiring that State Medicaid plans "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payment (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

Later, during the Senate Finance Committee hearings proceeding the enactment of the 1972 Amendments, great concern was expressed over "the effect of overutilization on the health of the aged and the poor. Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care." Just as importantly, testimony reflected concern with "the many instances of underutilization or the absence of certain needed services."

The 1972 Amendments which enacted mandatory controls over the use of institutional health services were, therefore, the result of a cumulation of events. Section 1903(g) of the Act (the section relating to utilization controls) was added by the Amendments as an effort to bring to bear on the Medicaid program the knowledge gained from various review activities for controlling the utilization of medical services, as well as to ensure the implementation of the methods which numerous hospitals and nursing homes had developed to manage their services. (For detailed discussion, see *Hospital Utilization Project, Utilization Review Training Manual*, Pittsburgh, Pa.)

Defining Utilization Control

Before going further, an understanding of the term *utilization control* as applied to institutional care (inpatient care in hospitals, skilled nursing facilities (SNF),[1] intermediate care facilities (ICF),[2] and mental hospitals (MH)[3]) is necessary. Utilization control has a much broader meaning with respect to institutional services than the more familiar term utilization review, which is explained below. Section 1903(g) of the Social Security Act refers to a "program of control over utilization of such (institutional) services" which must include certain components listed in the section. Collectively, UC covers the following Medicaid requirements or components: A physician's certifica-

tion and 60-day recertifications of the need for institutional care, a plan of care for each patient developed and periodically reviewed by a physician, utilization review, medical review in skilled nursing facilities and mental hospitals, and independent professional review in intermediate care facilities.

Certification. Physicians are required to certify at the time of admission (or at the time of application for medical assistance) that hospital, SNF, MH, or ICF services are necessary on an inpatient basis because the person needs such service. *Recertification* of need for care must also be attested to by a physician at least every 60 days following the original certification.

Plan of Care. It includes all items of care and services ordered by a physician, in conjunction with other medical and social service personnel, which contribute to the improvement or maintenance of a patient's physical, psychological, and social condition.

Utilization Review. Briefly, this refers to assessing the necessity for admission for inpatient care and service and periodic reassessment for continued inpatient care. This assessment must be made by medical and other professional personnel who are not directly responsible for the patient whose care is being reviewed. Findings must be analyzed and corrective actions taken where indicated.

Medical Review. States must provide for a program of medical review of each patient's need for skilled nursing facility or mental hospital care by means of a medical evaluation and a written plan of care prior to admission or authorization of payment and at least annual onsite inspections by medical review teams composed of physicians and other appropriate health and social service personnel. Onsite inspections determine the adequacy of services available to meet health needs and promote optional physical, mental, and psychosocial functioning; the necessity and desirability of continued placement; and the feasibility of alternatives.

Independent Professional Review (IPR). The process, provided by the State, assesses each resident's need for intermediate care. It is similar to the medical review in skilled nursing facilities and mental hospitals. IPR includes a comprehensive medical, social, and psychological evaluation; a written plan of care prior to admission or authorization of payment; and at least annually an onsite inspection by IPR teams. These are composed of physicians or registered nurses and other appropriate health and social service personnel. Onsite inspections determine the adequacy of services to meet health, rehabilitative, and social needs; the appropriateness and quality of services actually being rendered; the necessity and desirability of continued placement; and the feasibility of alternative placement.

Managing UC

The controls over utilization of institutional services detailed above are necessitated, not because of flagrant abuse, but as a result of laxity in programing and planning. In the medical industry, focus has been concentrated to such as extent upon the service itself that sight has often been lost of the most efficient and effective means of providing that service.

The rationale behind section 1903(g), the Medicaid utilization control amendments added to Title XIX, therefore, becomes more apparent. The Medicaid program has substantial impact on welfare recipients (the patients), medical providers (doctors and institutions), legislative and executive bodies, and the tax paying public because of the large amount of State and federal tax funds expended in the program.

Programs implementing these controls must be designed primarily to educate the public and the professions regarding the need for the best utilization of health care services. Also, they must hold the line on expenditures. The basic principle, established both by medical practice and past history, remains that, in all cases requiring medical decisions, the judgment of the responsible attending physician is the most significantly weighted factor. The patients' need and the medical necessity for the services rendered must constitute the dominant criteria used in judgments. But, it is important that the proper tools be provided to ensure the carrying out of the program objectives in an effective and efficient manner.

Management in the States is responsible for establishing the necessary procedures, controls reporting, and feedback systems. Proper management is found in the action which adjusts operations to conform to prescribed or desired standards or requirements. To do this, the State needs timely and adequate information on performance, the source of which may be direct observation; routine and periodic accounting; statistical, analytical reports; audits;

and functional staff review.

Proper management, however, is predicated on the maximum use of controls and their feedback. Because Congress was so convinced of the value and effectiveness of the experience with controls over utilization in some States, it included an incentive for the States to implement the controls set forth in 1903(g). Federal financial participation under Medicaid would be decreased by 1/3 after any "individual has received care as an impatient in a hospital (including institutions for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year . . . unless . . . there is in operation in the State an effective program of control over utilization of such services."

Adherence to 1903(g) is to be validated by HEW, according to the legislation, through onsite sample surveys. In June 1973, therefore, the States were informed that until new utilization control regulations were published, they would be required to meet minimum utilization control requirements as specified in the 1972 Amendments and in existing regulations.

The first review of State adherence was begun in November 1973. Its aim was the identification of States which were or were not meeting the requirements or had made a valid attempt to do so by setting up procedures, making reasonable efforts to implement and monitor, and informing facilities of the requirements. Requirements and procedures at the State agency were reviewed and some facilities were surveyed in each State.

Since improved patient care and avoidance of waste are the aims, HEW will assist States in avoiding penalties. Following the initial surveys, HEW staff worked with 25 States to develop corrective plans that covered those requirements which the survey found wanting.

Benefits for State, Institution, Patient

Almost all 25 States had implemented plans of correction by June 1974. Thus, the benefits which accrue as a result of controls over utilization are bearing fruit. As the experience from the time of Florence Nightingale to the intensified management efforts of the last 20 years have demonstrated, UC benefits the State, the institution, and the Medicaid patient.

The Federal Government and the States are hardest hit by the rising costs of Medicaid. UC, then, assures authorized services and their efficient and effective delivery. It also insists on the timely delivery of those services.

In turn, the institution benefits. It furnishes an education to its staff through critical self-analysis of the quality of its care and the determination of the proper use of its facilities. Two factors operating in this regard are length of stay by diagnosis and professional feedback on care.

Lastly, but most importantly, the patient and his family benefit. This comes through confidence, confidence that the service being received is not only adequate and appropriate but adequate and appropriate for the patient.

Ms. Leonard is a utilization control specialist in the Division of Utilization Control, SRS.

Notes

1) A skilled nursing facility (SNF) provides care to patients who do not require the level of medical care provided by an acute hospital but who require skilled nursing services or supervision by a registered nurse on a continuing basis. An SNF provides 24-hour supervision by licensed nursing personnel, physicians, dieticians, rehabilitationists, pharmacists, laboratory and radiological specialists, and personal care personnel.

2) An intermediate care facility (ICF) is an institution which is licensed under State law to provide, on a regular basis, health related care and services to persons who do not require the degree of care and treatment which a hospital or SNF is designed to provide. These residents, however, require care and services above the level of room and board, available only through institutional facilities. In addition to personal care services, the ICF provides health, physician, dietary, pharmaceutical, therapeutic, social, and recreational services.

3) An institution for mental disease (IMD) primarily provides diagnosis, treatment or care (including medical attention, nursing care, and related services) of persons with mental diseases. An IMD is additionally classified as a hospital, SNF, ICF, or combination thereof, depending on the level of care provided. Services under Medicaid in IMDs are limited to hospital, SNF, and ICF services under Medicaid for persons over 65 and to hospital services for those under 21.

TABULATING MACHINE OPERATOR I. (continuous recruitment) H.S. graduate or equivalent and completion of a formalized course in data processing of at least 9 mos. Or, 6 mos. of full-time experience in the operation of tabulating equipment may be substituted for the required data processing training. Apply: Director, West Virginia Civil Service System, 1900 Washington St. E., Charleston, W.Va. 23511.

NURSING AIDE I. (continuous recruitment) No education attainment level or experience required. Write: Director, West Virginia Civil Service System, 1900 Washington St. E., Charleston, W.Va. 23511.

PSYCHIATRIC AIDE I. (continuous recruitment) Must be able to perform subprofessional psychiatric nursing work in a ward of a State mental institution. Must pass a written test. Write: Director, West Virginia Civil Service System, 1900 Washington St. E., Charleston, W.Va. 23511.

HOME HEALTH AIDE. (continuous recruitment) Successful completion of a home health aide training course approved by the State health department prior to employment or within 6 mos. after employment. Write: Director, West Virginia Civil Service System, 1900 Washington St. E., Charleston, W.Va. 23511.

PSYCHIATRIST I. (continuous recruitment) Possession of a degree of doctor of medicine, supplemented by completion of a recognized residency program in psychiatry. $18,648–26,334. Write: State Personnel Office, Townsend Building, Dover, Del. 19901.

PSYCHIATRIST II. (continuous recruitment) Ph.D. degree and successful completion of a program of internship, supplemented by completion of a recognized residency program in psychiatry and 2 yrs. of progressively responsible professional experience in psychiatry. $20,664–28,980. Write: State Personnel Office, Townsend Building, Dover, Del. 19901.

PHYSICAL THERAPIST I. (continuous recruitment) Bachelor's degree including or supplemented by successful completion of a course in physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, or from a school certified by the American Physical Therapy Association as its equivalent. $8,543–12,096. Write: State Personnel Office, Townsend Building, Dover, Del. 19901.

PHYSICAL THERAPIST II. (continuous recruitment) Bachelor's degree including or supplemented by successful completion of a course in physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or from a school certified by the American Physical Therapy Association as its equivalent, and 2 yrs. of progressively responsible professional experience in physical therapy. Possession of a master's degree in physical therapy or in public health may be substituted for 1 yr. of the required experience. $10,420–14,616. Write: State Personnel Office 1228 N. Scott St., Wilmington, Del. 19806.

PROJECT DIRECTOR. Master's degree or Ph.D. preferred, but not essential; familiarity with research methods, health manpower data sources, and health care systems. $15,600. Some room for negotiation. Write: Health Manpower, 400 Watkins Bldg., 510 George St., Jackson, Miss. 39201.

OCCUPATIONAL THERAPIST II. (continuous recruitment) Bachelor's degree including or supplemented by successful completion of a course in occupational therapy, and 2 yrs. of responsible professional experience in occupational therapy. A master's degree in occupational therapy, special education, or public health may be substituted for 1 yr. of the required experience. $10,420–14,616. Write: State Personnel Office, 1228 N. Scott St., Wilmington, Del. 19806.

DIRECTOR OF PROGRAM PLANNING, DEVELOPMENT, AND EVALUATION. (continuous recruitment) Master's degree in social work or related field and 5 yrs. of responsible social work experience, 2 yrs. of which must have been in providing administrative, supervisory or consultative services; or bachelor's degree in social work or related field and 6 yrs. of experience of the type specified above, 2 yrs. of which must have been in providing administrative, supervisory or consultative services; or an equivalent combination of training and experience. $12,726–17,766. Write: State Personnel Office, Townsend Building, Dover, Del. 19901.

TRANSCRIBING MACHINE OPERATOR. (continuous recruitment) HS graduate or GED certificate, including or supplemented by coursework in typing and transcribing machine operation, and 2 yrs. of varied typing and clerical experience; additional experience may be substituted on a year-for-year basis for up to 2 yrs. of the required high school education; successfully completed post high school training in clerical studies, including course work in typing and transcribing machine operation, may be substituted on a year-for-year basis for the required experience. $4,739–6,336. Write: State Personnel Office, Townsend Building, Dover, Del. 19901.

MANAGEMENT ANALYST I. (continuous recruitment) Master's degree in business or public administration or closely related field; or bachelor's degree in business or public administration or closely related field and 1 yr. of experience of an analytical nature involving management and control, gathering and analyzing data and preparing reports and recommendations; or associate degree in business studies or closely related field and 3 yrs. of experience; or an equivalent combination of training and experience. $9,437–13,356. Write: State Personnel Office, Townsend Building, Dover, Del. 19901.

MANAGEMENT ANALYST III. (continuous recruitment) Master's degree in business or public administration or closely related field and 2 yrs. of experience of an analytical nature involving management and control, gathering and analyzing data and preparing reports and recommendations, including 1 yr. in management analysis or closely related work; or bachelor's degree in business or public administration or closely related field and 3 yrs. of experience, including 1 yr. in management analysis or closely related work; or associate degree in business studies or closely related field and 5 yrs. of experience, including 1 yr. in management analysis or closely related work; or an equivalent combination of training and experience, which includes 1 yr. in management analysis or closely related work. $11,466–16,128. Write: State Personnel Office, Townsend Building, Dover, Del. 19901.

INSTRUCTOR IN APPLIED PHYSICS. BA degree with a major in the field to be taught or in a related technical or engineering field. Previous experience reasonably related to the duties and functions to be performed. Shall be approved by the Department of Occupational Education and Technology. Salary: open. Write: E. R. Billings, General Manager for Instruction, James Connally Campus, Texas State Technical Institute, Waco, Tex. 76705.

BIOLOGIST I (Computer Programer). A 6-year combination of exp. and education comprised of 2 yrs. exp. in the development of computer programs related to the biological or natural resource fields, and graduation from an accredited 4-yr college or university with specialization in biology, statistics and computer theory and/or programing or any combination of related and equivalent military or civilian training and/or exp. totaling 6 yrs. $169.70–205.50 per/wk. Write: Maine State Department of Personnel, Augusta, Me. 04330.

BIOLOGIST II (Computer Programer). A 7-year combination of exp. and education comprised of 3 yrs. of progressive exp. in fisheries or wildlife management including exp. in statistics and computer programing/modeling, and graduation from a 4-yr. college or university with a degree in fisheries or wildlife management and emphasis on statistics and computer programing/modeling or any combination of related and equivalent military or civilian training and/or exp. totaling 7 yrs. $195.80–237.70 per/wk. Write: Maine State Department of Personnel, August, Me. 04330.

STAFF ARTIST. A background in photography is highly desirable, however, a person willing to work and put in the necessary effort should be able to master the job within a short duration of time. Write: E. R. Billings, General Manager for Instruction, James Connally Campus, Texas State Technical Institute, Waco, Tex. 76705.

MAINTENANCE TECHNICIAN. This person should be able to work on electro/mechanical equipment. Most work will be in the repair and maintenance of audio-visual equipment such as 16mm projectors, tape recorders and other electro/mechanical equipment. Occasionally there will be other electrically oriented equipment such as an osciloscope and equipment that must be calibrated. A background of work experience in this area is desirable, but not mandatory. A person with recently acquired education in this area will be considered. Write: E. R. Billings, General Manager for Instruction, James Connally Campus, Texas State Technical Institute, Waco, Tex. 76705.

MEDIA SUPERVISOR. BA degree in the area of instructional media is highly desirable, but not mandatory. This position requires a person to work in several areas of instructional media in a highly sophisticated instructional media center which has a two fold purpose, teaching instructional media technology and support of the faculty in the production of their instructional materials. Write: E. R. Billings, General Manager for Instruction, James Connally Campus, Texas State Technical Institute, Waco, Tex. 76705.

Mail your agency's classified listings to Editor, SOCIAL AND REHABILITATION RECORD, DHEW-SRS, Washington, D.C. 20201. Applicants should apply directly to the hiring agency, NOT this magazine. No "situation wanted" or non-governmental listings accepted. There is no charge or fee of any kind for this service.

MEDIA TECHNICIAN. BA degree in the area of instructional media or a related field is highly desireable. This position requires a person to work with equipment in several areas of instructional media in a highly sophisticated instructional media center which has a two fold purpose, teaching instructional media technology and support of the faculty in the production of their instructional materials. Write: E. R. Billings, General Manager for Instruction, James Connally Campus, Texas State Technical Institute, Waco, Tex. 76705.

REGIONAL MENTAL RETARDATION ADMINISTRATOR. Ph.D. or MA degree in a discipline appropriate to the care, treatment or education of the mentally retarded, and the person shall have had at least 4 yrs. of exp. in a professional position in mental retardation services equivalent exp. as determined by the commissioner. He or she should be a neat person with drive, imagination, talent for management. Write: Dr. Lewis B. Klebanoff, Assistant Commissioner for Mental Retardation, Department of Mental Health, 190 Portland Street, Boston, Mass. 02114.

REPRODUCTION EQUIPMENT OPERATOR. HS graduate or equivalent. Typing preferable. Ability to deal with fellow staff members under stress of deadlines. Operate Robertson 580 Process Camera in reproduction of linework and halftones. Platemaking on surface coated presensitized plates. Stripping for single and multiple color. Some pasteup. Two yrs. exp. or formal training. Write: E. R. Billings, General Manager for Instruction, James Connally Campus, Texas State Technical Institute, Waco, Tex. 76705.

BINDERY SUPERVISOR. General bindery operation, including power cutter, folder, sorter, collator, drill, plastic binding, padding, fan-apart compound forms, and wrapping and packaging. Final approval of jobs, quality and quantity. Supervise student employees. Interpret job jackets. Be able to work with other staff members under pressure of deadlines. Three yrs. exp. Write: E. R. Billings, General Manager for Instruction, James Connally Campus, Texas State Technical Institute, Waco, Tex. 76705.

SECRETARIAL AND CLERICAL JOBS. The secretary requirements are as follows: must have the ability to use shorthand and dictaphone. Typing should be approximately 50 words with a minimum of 4 errors. HS diploma or equivalent is desirable. For clerical, typing qualifications are the same as above except the use of shorthand and dictaphone are not required. Write: E. R. Billings, General Manager for Instruction, James Connally Campus, Texas State Technical Institute, Waco, Tex. 76705.

EMPLOYMENT INTERVIEWER I. BA degree in a social or behavioral science or closely related field; or AA degree in business studies, social service studies or closely related field and 2 yrs of progressively responsible exp. in employment interviewing, personnel administration or closely related field; or HS graduate or GED certificate and 4 yrs. of exp. of the type specified above; or an equivalent combination of training and exp. $8,322—12,696. Write: Intergovernmental Job Center, Federal Building, 844 King Street, Wilmington, Del. 19801.

Seminar on leprosy to be held in spring

The 16th annual American Leprosy Missions, Inc., seminar on leprosy will be held at the U.S. Public Health Service Hospital, Carville, La., from April 3 to 9, 1975. There are no expenses involved in attendance except travel to and from New Orleans.

Lecturers are drawn from experienced specialists on the Carville staff and specialists involved with leprosy work elsewhere in the U.S. and abroad.

Early application is invited. Applicants will be notified of their acceptance not later than March 1. For application form, write to American Leprosy Missions, Inc., 297 Park Avenue South, New York City 10010.

Deaf awareness year declared thru July

August 1974 through July 1975 has been designated as Deaf Awareness Year One. The national office of the Registry of Interpreters for the Deaf (RID) kicked off the campaign by sending buttons, decals, bumper stickers, and brochures to State RID chapters across the Nation.

The National Grange Women's Activities financed the production of Deaf Awareness TV public service spot announcements, which were sent to 125 stations across the Nation. The spots feature *I Hear Your Hand,* a song written by T. Daniel Robbins (music) and Mary Jane Rhodes (words). It is performed by Rita Corey, a Gallaudet student, Bill Ennis a deaf man, and students from the Kendall Elementary Demonstration School for the Deaf.

The RID Deaf Awareness Year One goal is to have one button, decal, or bumper sticker displayed for each of our Nation's deaf Americans. There are approximately 500,000 citizens who became deaf before age 19.

Hearing not improved through acupuncture

There is no evidence of significant improvement in hearing as a result of acupuncture treatment, two experts in audiology at Pennsylvania Temple University report in the August 1974 edition of the *Journal of the American Speech and Hearing Association.*

After research involving patients who had received acupuncture treatment for sensori-neural hearing impairments, Dr. John D. Durrant and Sandra Katinsky, using standard tests, observed that "regardless of the test parameter examined, without exception, the greatest percentage of ears showed no clinically significant change. While a small proportion of the total sample demonstrated changes in either direction, the greatest percentage showed poorer hearing for puretone thresholds, speech reception or awareness thresholds, and discrimination ability following 10 acupuncture treatments."

"Certainly, our results are in contrast to the claim of at least one acupuncture center 'that approximately 60 percent of patients treated by acupuncture for nerve deafness have shown significant improvement,'" the researchers said. Further, they said, "We have a responsibility to respond to the inquiries of the hearing-handicapped population concerning the effectiveness of acupuncture treatment of hearing disorders. Notwithstanding the limitations of our study, . . .we feel justified in concluding that our data indicate that there is no evidence of significant improvement in hearing following acupuncture treatment."

Mayors speak

The U.S. Conference of Mayors, at their summer meeting in San Diego, unanimously passed a resolution declaring that the Conference of Mayors "does strongly support the concept of removal of the architectural barriers and goes on record as encouraging builders, designers, architects, and planners to take into full consideration the great advantages to be gained through barriers-free buildings and other facilities."

Appointments, honors, etc.

The Voyle C. Scurlock Region VI Award was presented to **Vernon J. Broussard,** Administrator, Services for the Blind, Louisiana. The annual award is given to a person in the rehabilitation field who has made outstanding contributions to the profession, is a leader, and is recognized for total dedication and effort to the cause of the handicapped. The presentation was made at the Regional Conference in Albuurque.

Richard W. Bleeker, North Plainfield, N.J., has been appointed director designate of the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC). He will become executive director on January 1, 1975.

Dr. Peter J. Salmon received the Hadley School for the Blind's Richard Kinney Challenge of Living Award for 1974. The presentation was made in Sao Paulo, Brazil, at the World Council for the Welfare of the Blind. It was presented "in recognition of his devoted life of extraordinary, pioneering service to deaf-blind persons. . . ."

AFDC Monthly Payments to Families
1973

Dollar amount	Number of Families	Percent of total
$1-24	69,183	2.3
25-49	192,417	6.4
50-74	210,115	7.0
75-99	276,606	9.3
100-149	503,608	16.8
150-199	537,405	18.0
200-249	464,804	15.5
250-299	296,223	9.9
300-399	322,473	10.8
400-499	86,567	2.9
500 and over	30,490	1.0

The total number of AFDC families was 2,989,891. Minimal samples for the study were required of each State was one-half of one percent. Thirty-three States provided samples large enough for reliable data to be shown in the tabulation. (Data source is the National Center for Social Statistics report, *Findings of the 1973 AFDC Study*, Part II-A, Financial Circumstances, DHEW Publication number (SRS) 75-03765. Figures are based on families who received an assistance payment in January 1973.)

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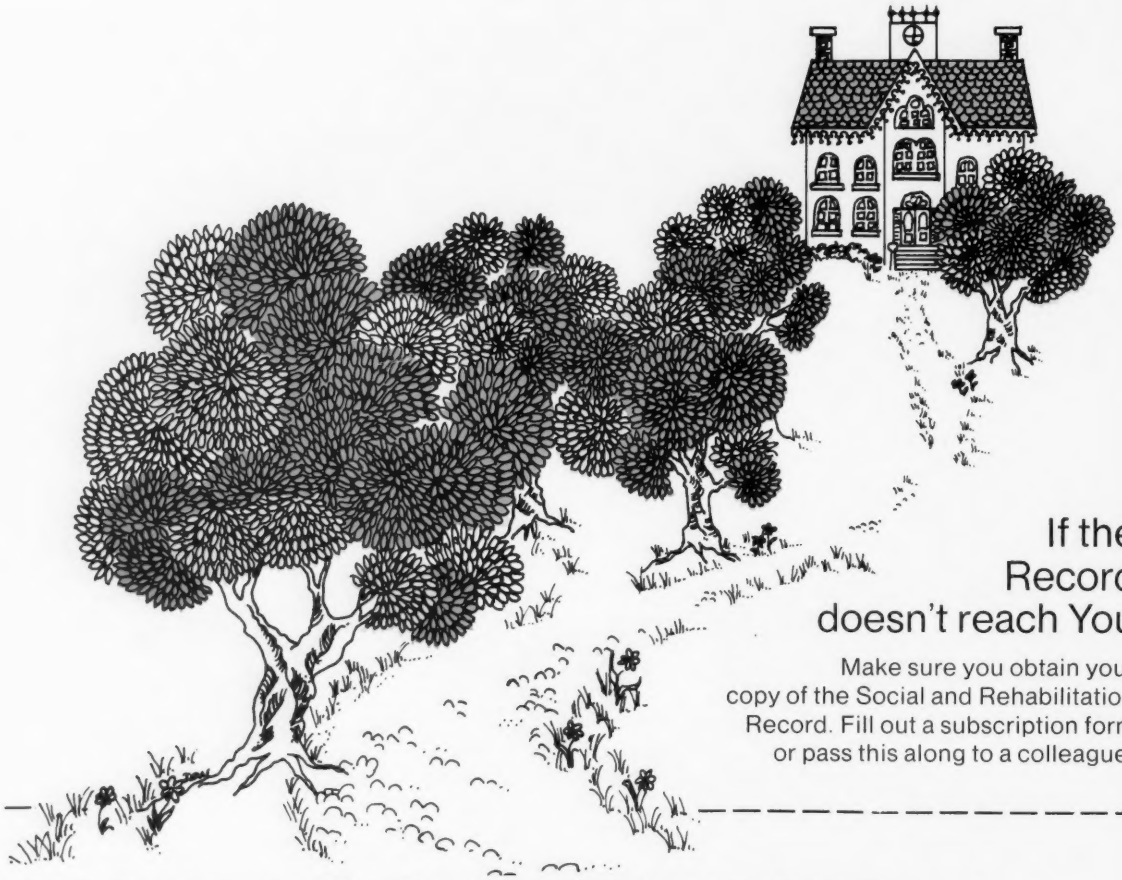

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